DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 10171 (01/06)

AGENCY POSITION ON THE PAYMENT ERROR RATE MEASUREMENT (PERM) ERROR FINDING

Complete, sign and return this form with documentation to the address below.

Wisconsin Department of Health & Family Services
Division of Health Care Financing
Bureau of Eligibility Management / Attn: Payment Error Rate Measurement
P.O. Box 309
Madison, WI 53701-0309

CARES Case Number	**Case Name**

☐ **We agree with the error finding.**
If necessary, correct the case and submit documentation of your corrective action within 30 days. If an overpayment occurred due to client error, establish a claim to initiate benefit recovery. For error reduction initiatives, what information from the client, agency or state would have helped prevent this error? **Please respond within 30 days.**

☐ **We disagree with the error finding.**
Provide additional information and/or documentation to explain why you feel the eligibility determination was correct. **Please respond within 14 days.**

SIGNATURE – Agency Representative	Title/Position	Date Signed

AGENCY NAME